Medicaid and the Limits of State Health Reform

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adopted various policies to ease the transition. High-cost facilities could, for example, receive a reimbursement bonus (or an amount above the figure generated by the case-mix calculation). And the state established a program to transfer millions of dollars from homes that profited under the new system to homes that suffered financial losses.[50] With these additions, the impact of the new system proved to be far less onerous than first feared. To be sure, nursing homes are today admitting a more disabled population, and less sick patients (who presumably should be steered into home health care programs) are now the ones languishing in hospital beds. But Medicaid reimbursement to most nursing homes continues to rise, particularly as homes admit increasing numbers of disabled patients. Moreover, the nursing home industry continues to be quite profitable: a Department of Health survey concluded that the state's 284 for-profit homes generated $163 million in profits in 1992; the 200 nonprofit homes generated a surplus of $37 million; while the 43 public facilities, which showed a net loss of $11 million, generally recouped their losses from their local governments.[51]

The implementation of the case-mix system illustrates nicely the political context of nursing home reimbursement in New York. Nonprofit nursing homes originally supported the new system because they thought it would confirm that they treated the most disabled patients and thus would provide them with even greater reimbursement. When that assumption proved to be inaccurate, they revised their position (and their admission practices) and persuaded state officials to ease the impact of the new system. Advocates too initially supported the new approach, believing it would encourage fairer admission practices and improved quality of care. These advocates now complain that (many) nursing homes are using their increased revenue to increase profit margins rather than patient services.[52] State officials, responsive both to the advocates and to the nursing home industry, continue to push nursing homes to improve quality and pay them well for doing so. The lesson: nursing home reimbursement policy in New York

emerges continually from the pulling and tugging of a pluralistic political environment.

Policy in California: Autonomous Officials Keep Costs Low

In 1966, newly elected California Governor Ronald Reagan pressed state officials to develop policies that emphasized Medicaid cost containment. In response, officials implemented a novel but simple approach: decide how much the state would spend on nursing home care and cap spending at that amount, impose minimal regulatory oversight over nursing home behavior, and permit facilities with low costs to make a profit.

To implement this cost-containment policy, however, state officials had to centralize the Medicaid decision-making process. Groups that wield significant political clout in New York (particularly nursing home lobbyists, union officials and client advocates) were generally unable to penetrate the decision-making process in California. Instead, these groups lingered on the periphery, occasionally challenging state actions in court, but more typically adapting and adjusting to state policies.

Consider, first, reimbursement policy in California in the late 1960s and early 1970s. By state law, nursing homes were to be reimbursed for their "reasonable costs." Early on, however, the state's finance department established maximum per diem rates for nursing homes. Facilities received no more than the rate ceiling, regardless of actual costs. Moreover, the finance department, with its emphasis on cost containment, kept the rate ceilings relatively low. In 1971, the maximum rate for a nursing home in California was $14 per day, versus an average of $22.70 in New York.[53]

Unable to influence the administrative bureaucracy informally, California's nursing homes convinced a federal judge to order the state Medicaid agency to hold public hearings on the issue of rate methodology.[54] The agency held the hearings but rejected all requests for a facility-specific reimbursement system, adopting instead an explicitly flat-rate system.[55]

The methodology adopted in 1972, with some minor changes, remains in effect today. The system works as follows. (1) Nursing homes submit cost reports to the Department of Health Services. (2) The department audits the reports and determines the median costs for several classes of facilities (based on size, level of care, and location). (3) The department establishes a reimbursement rate for each class (by taking the median costs for each class from a year earlier and adjusting those figures for inflation). (4) Nursing homes in a particular class receive the same reimbursement rate, regardless of actual costs. If their costs are below the rate, the home keeps the difference as profit. If their costs exceed the rate, the difference represents a loss.[56]

The California system produces relatively low reimbursement rates. In 1980, California ranked thirty-eighth among the states in Medicaid expenditures per nursing home resident.[57] Nearly a decade later, in 1989, California ranked forty-fourth. Also in 1989, California ranked twenty-sixth in rates paid to skilled care facilities, with a rate of $60.26 per day (New York ranked fifth, with a rate of $112.93; the national mean was $70.06).[58] Given this variation, it is hardly surprising that, in 1991, New York's program spent $3.8 billion more on its aged recipients than did California ($5.74 billion to $1.94 billion), even though California had 120,000 more aged beneficiaries.[59]

Not surprisingly, many nursing home owners would prefer a facility-specific system in which homes were reimbursed for their actual costs. Nonetheless, the industry, which is dominated by for-profit facilities, has adjusted by keeping employee wages low and by spending relatively little on efforts to improve patient care.

Consider the wage issue. In California only 15 percent of the nursing home workforce is unionized. Indeed, until the early 1980s, health care unions made only minimal efforts to organize California's nursing home workers. The result is that wages are dramatically lower than in New York, where health care unions represent a potent political force. In 1985, for example, a typical nurse's aide in New York City made $8.50 per hour; in Los Angeles a typical aide earned approximately $4.48 per hour.[60] Nearly a decade later, the entry level salary in California for a nurse's aide was only $4.50 an hour, while the average aide's salary was $6.20. Moreover, the average staff turnover rate in California nursing homes is approximately 90 percent.[61]

Consider also quality of care. For years, patient advocates argued that flat-rate reimbursement systems encourage facilities to spend as little as possible on worker training and patient services, and thereby discourage high-quality care. But state officials (including maverick Governor Jerry Brown) were unwilling to raise reimbursement rates (even if the additional funds were targeted to patient care services). Instead, state regulators and nursing home owners lived by an unwritten agreement: while reimbursement rates were low, regulatory oversight was minimal.

This informal working arrangement was challenged, in 1983, when the Commission on California State Government Organization and Economy (a state oversight agency known generally as the "Little Hoover Commission") issued a highly publicized report detailing both the quality-of-care problems in the state's nursing homes and the state's bureaucratic inattention.[62] California nursing homes were notorious, for example, for being understaffed and for using both physical and chemical restraints to keep patients docile. Moreover, the state's licensing and certification division was itself understaffed, and when state inspectors did find deficiencies and impose penalties, nursing homes were expert at evading and avoiding compliance.

Following the release of the Little Hoover report, the state legislature itself held oversight hearings, and it eventually enacted a new Nursing Home Patient Protection Act. But while the new law imposed minimum quality standards and toughened the penalties for noncompliance, the state Medicaid agency neither increased rates (to enable facilities to meet the new requirements) nor significantly increased its auditing staff (to ensure facility compliance).

Nursing home industry lobbyists, while defending the quality of patient care, now framed their request for a revised reimbursement

system as a patients' rights proposal. Patient advocates, union officials, and liberal legislative staffers allied on this issue with the industry. Even the state's Auditor General recommended that California adopt a facility-specific cost-based reimbursement system, arguing that flat-rate systems inevitably encourage poor quality. It was clear, however, that without the support of the state's Medicaid bureaucracy and the governor, the coalition's efforts would not succeed.

In 1987, however, the dynamics of the policy process changed dramatically for the first time in twenty years. Congress enacted a series of nursing home quality-of-care reforms that were to take effect October 1, 1990.[63] The reforms required nursing homes throughout the country to meet minimal standards on several counts, from staff/patient ratios to staff training to patients' rights (nursing homes were required to justify, for example, the use of physical and chemical restraints). The reforms also required states to include the cost of complying with the new standards when developing Medicaid reimbursement rates.[64]

It was soon clear that Congress's actions could undermine California's ability to restrain nursing home costs. Indeed, in January 1990, the California Association of Health Facilities (representing over eight hundred nursing homes) estimated that California's nursing homes would spend over $1.3 billion annually to implement the federal reforms. State officials placed a $400 to $600 million price tag on the implementation process. (Implementing the reforms in New York, in contrast, was expected to cost less than $20 million per year because the state already required its nursing homes to meet tough quality standards.)[65]

California officials, anxious to avoid higher nursing home costs, developed a daring strategy: they accepted an important revision in the state's Medicaid reimbursement formula but conditioned it upon a federal waiver from the new quality-of-care requirements. Specifically, the state's executive branch supported a legislative amendment (sponsored by nursing home owners, patient advocates, and union leaders) that would provide nursing homes with an additional $100 million per year to be spent on direct patient care services. However, the legislation also contained "poison pill" language (opposed by the key interest groups): if in 1991 or 1992 the federal government or any court required California to spend money complying with the federal reforms, the new reimbursement scheme would be voided.[66]

State officials then began a vigorous lobbying campaign to persuade the Health Care Financing Administration (HCFA) or Congress to grant the state a waiver from the federal quality-of-care reforms. This effort was particularly intriguing because the primary sponsor of the federal reforms was a Democratic congressman from Los Angeles, Henry Waxman. The goal was to persuade Waxman, and others, that HCFA was interpreting the congressional mandate too expansively. According to this argument, the cost (in time, paperwork, and money) of the new reforms (as interpreted by HCFA) clearly outweighed any benefit in patient outcomes.

Not surprisingly, Waxman was unpersuaded, and legal services lawyers challenged in court the state's failure to implement the reform legislation. A federal judge then issued an injunction ordering state officials to comply with the new law. Despite the judicial decision, state officials were not ready to concede defeat, although they did void the 1990 state legislation that would have provided California's nursing homes with an additional $100 million in reimbursement. At the same time, the state commenced its own lawsuit against HCFA, challenging as unlawful HCFA's interpretation of the reform legislation. HCFA responded by sending 111 (of the 139) federal nursing home inspectors to the state to ensure nursing home compliance with the new law (normally state inspectors are charged with that task). HCFA also withheld $24 million in federal reimbursement to penalize the state for its noncompliance.

While the HCFA officials talked tough, and while the state's lawsuit was pending, newly elected Governor Pete Wilson made a

personal appeal to President George Bush,[67] convincing the president to overrule his federal regulators: on March 11, 1991, HCFA suddenly agreed that its "interpretative guidelines" were not mandatory, that it would consider more carefully California's objections to the guidelines themselves, and that California could delay its implementation of the reform legislation pending the "new look."[68]

With this federal concession, the dispute moved back to the courts as legal services advocates challenged the HCFA retreat. Some time later, after much political and judicial maneuvering, the court again ordered the state to comply with the federal law (as interpreted by HCFA), rendering moot HCFA's (half-hearted) argument to the contrary.[69] Following this decision, the state (finally) agreed to begin implementation.

The remaining question, however, was whether the new requirements would lead to dramatic increases in Medicaid expenditures. After all, the industry had estimated the cost of implementation at $1 billion, and the state had estimated half a billion. But with implementation now underway, state officials (not surprisingly) were suddenly downplaying the cost of the new law, and refusing to grant any significant reimbursement increases. The issue again moved to the courts, as the nursing homes alleged that the state was violating federal reimbursement requirements. In July 1993, however, the industry and the state settled: nursing homes would receive $2 per bed per day to comply with the federal quality-of-care reforms. The estimated cost to the state: $49 million in fiscal year 1994.[70]

It may be that the nursing home industry and the state both grossly overestimated the cost of the new federal reforms. Or perhaps state officials are inadequately enforcing the new requirements (as patient advocates today insist). Or maybe the state is simply underpaying the state's nursing home facilities. The truth probably lies somewhere in between. What is quite clear, however, is that California officials are fighting to maintain their firm hold on Medicaid expenditures on nursing homes.

Policy in New York and California: Bureaucratic Variation Produces Program Variation

This chapter began with a question: Why does Medicaid in New York pay nursing homes almost twice as much as Medicaid in California? The subsequent examination of the two states reveals a two-fold answer. First, California's Medicaid bureaucrats have more discretion to implement policy than do their counterparts in New York. Key interest groups (including union officials, nursing home owners, and client advocates) are more influential in New York than in California. Second, California's Medicaid bureaucrats have used their discretion to implement a cost containment regime. The result is the flat rate reimbursement system combined with the historically low flat rates. In New York, by contrast, health care unions have produced relatively high wages for their members, owners of nonprofit nursing homes have used low-interest state loans to build elaborate and expensive facilities, and consumer advocates have persuaded state officials to implement a rigorous set of quality-of-care regulations.

This is not to suggest, of course, that interest groups in California are irrelevant or that state bureaucrats in New York are ineffectual. During the mid-1970s, for example, New York regulators demonstrated their ability to control nursing home costs. The implementation of the case-mix reimbursement system in the 1980s also required significant administrative capacity. At the same time, consumer advocates in California used litigation to require the state to implement federal quality-of-care standards, and the nursing home industry bargained with state officials over a rate increase to pay for the new standards.

On the whole, however, the dominant pattern in New York is one of pluralism and high cost, while the pattern in California tilts toward bureaucratic discretion and low cost. Variation in policy-making environments produces variation in program outcomes.